RESTON PODIATRY ASSOCIATES, LTD.

Patient's FIRST_________________________M.I. ______LAST_______________________________SEX:_____

Home Address ____ City ___________________________

State ______Zip _________-_____Home Phone: ___________________ Cell Phone: ____________________

E-MAIL:______________________________SSN:_____-_____-______ AGE: ______ DOB: _____/____/_____

Race (Please Circle) American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, Other

Ethnicity (Please Circle) Hispanic or Latino, Non Hispanic or Latino

Marital Status: (S M D W SEP) Patient's occupation ____

Employer _______________________________ Work Phone ( ) ____________________________________

Address ____ City/State/Zip ___________________________

Name of Financially Responsible Person ____

Patient Spouse Parent Other Responsible Person's DOB: ____/____/______SSN:____-____-_____

Address (If different from patient) ____

Parent's name (If patient is minor) ____

Parent's Employer __________________________________ Parent's Occupation _________________________

Mother's Work Phone ___________________________Father's Work Phone _____________________________

Name of nearest relative not living with you ____

Address __________________________________ City/State/Zip ____

Home Phone _____________________________ Work Phone ____

Referred to Our Office By: ____

MEDICAL INSURANCE INFORMATION

WE INVITE YOU TO DISCUSS ANY QUESTIONS REGARDING OUR SERVICES OR OUR FEES.
THANK YOU.

Form Approved 05/07/2019

Patient Name:______________________________D.O.B____/____/_____

CHIEF CONCERN/PRESENT ILLNESS:

What is your current foot/ankle problem ____

Is your current foot/ankle problem: Left___________ Right _____________ Both ___________________________

How long have you been bothered by the above ____

What have you done for your foot/ankle problem ____

Was your foot/ankle problem a result of an accident ________ If so, date of accident ______________________

Circumstances of accident ____

MEDICAL HISTORY:

Family Physician's Name _______________Address __________________________ Phone: ________________

Are you now or have you been under a physician's care during the past 2 years: Yes ________ No __________

Date of Last Physical exam _______________ Are you presently taking any medication Yes ___ No _________

If yes, name of medication(s):____

____

Have you ever tested **positive** for Human Immunodeficiency Virus (HIV) Yes _____ No ________

Have you ever tested **positive** for a communicable disease (e.g. Hepatitis, Tuberculosis, Syphilis, Gonorrhea, Chlamydia, Herpes Simplex) Yes ___ No ___ Name of condition ____

Do you have a history of Alcoholism or Drug Dependency? Yes_____ No ______

Are you Pregnant? Yes _____ No _____

Do you use tobacco? Yes _____No ______ If yes, what type/how often ________________________________

Check if you have been treated for:

____ Allergies	____ Asthma	____ Epilepsy	____ Kidney Disease
____ Anemia	____ Bleeding tend.	____ Glaucoma	____ Liver Trouble
____ Anxiety	____ Blood Clot (DVT)	____ Gout	____Nervous Condition
____ Arthritis (Osteo)	____ Broken Bones	____ Heart disease	____ Reflux (GERD)
____ Arthritis (Rheum)	____ Cancer	____ Hepatitis	____ Stroke (CVA)
____ Arthritis (Other)	____ Depression	____ High Blood Pressure	____Thyroid
	____ Diabetes	____ High Cholesterol	____ Ulcers

Other ____

Have you ever experienced any unusual or allergic reactions to **LATEX/ADHESIVE** or **ANY Medications** (such as) Novocaine, Penicillin, Sulfa, etc: **If yes**, which one (s)____

Have you had surgery?:Type: ____ year ______________

____ year______________

Reviewed by Physician_____________________________________ **Date**____________________________

Form Approved 05/07/2019

Patient Name:____________________________D.O.B____/____/_____

FAMILY HISTORY:

Have any of your blood relatives had:

______Anesthesia Problems ______Cancer ______High Blood Pressure

______Arthritis ______Diabetes ______Kidney Disease

______Blood Clot (DVT) ______Heart Disease ______Obesity

Foot problems similar to yours ____

Is there any other general or foot health information that should be known? ________________________

____

- Virginia Law requires us to inform you that your blood may be tested for the HIV (AIDS) virus if any health care worker is accidentally exposed to your blood in a manner that could transmit HIV infection. Your consent is **NOT** needed, but you **will be** informed if tested.

- ***I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.***

Patient Name: ____

Patient Signature: ____

Parent/Guardian Signature: ____

Date: ________________________

Reviewed by Physician__________________________________ **Date**________________________

Form Approved 05/07/2019

PATIENT NAME ______________________________________D.O.B_________________

PATIENT ACCOUNT # ____

PATIENT IS: PLEASE CIRCLE ONE:

Employed Unemployed Full time student Part time student

PATIENTS RELATIONSHIP TO INSURED: PLEASE CIRCLE ONE:

Spouse Child Other: __________

PRIMARY INSURANCE:

SUBSCRIBER'S NAME ____

SUBSCRIBER'S DATE OF BIRTH ____

SUBSCRIBER'S SS# ____

SUBSCRIBER'S EMPLOYER ____

ADDRESS OF EMPLOYER ____

____

____

PHONE NUMBER: __(____)___________________________

SECONDARY INSURANCE:

SUBSCRIBER'S NAME: ____

SUBSCRIBER'S DATE OF BIRTH ____

SUBCRIBER'S SS#____

SUBCRIBER'S EMPLOYER____

ADDRESS OF EMPLOYER ____

____

PHONE NUMBER: ___(____)___________________________

ALL INSURANCE COVERAGE MUST BE DISCLOSED. FAILURE TO DO SO CONSTITUTES **FRAUD…**

Form Approved 05/07/2019

Patient Name:______________________________D.O.B____/____/_____

PATIENT AUTHORIZATION

I hereby authorize **RESTON PODIATRY ASSOCIATES LTD** to release medical information acquired in any examination or treatment, according to the following:

(ASSIGNMENT OF BENEFITS)

I request that payment of authorized insurance benefits be made to **RESTON PODIATRY ASSOCIATES LTD,** for services furnished to me by the physician.

(MEDICARE PATIENTS)

This office accepts Medicare assignment. Medicare patients are fully responsible, for the initial yearly deductible and the 20% co-payment. Federal law requires that physicians collect this amount. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related service

I also understand that I (husband, wife, dependent) am fully responsible for my charges, and filing of claims on my behalf by **RESTON PODIATRY ASSOCIATES LTD** is done, **PURELY AS A COURTESY.**

I understand that any outstanding balance after 90 days of the date of service will be referred to an outside collection agency for recovery. Accounts referred to an outside collection agency will be subject to a collection fee. Unpaid accounts will be reported to Equifax, TransUnion, Experian, and CBC Innovis.

PLEASE NOTE: A $25.00 WILL BE CHARGED FOR ALL RETURNED CHECKS.

PATIENT SIGNATURE ___________________________ DATE ___________________________

WE WILL WAIT UNTIL WE HEAR FROM YOUR INSURANCE COMPANY, THEN IT WILL BE YOUR RESPONSIBILITY TO CLEAR YOUR ACCOUNT IN FULL.

ALL COPAYS AND CASH ITEMS ARE PAYABLE ON THE DATE OF SERVICE

THANK YOU

WORKMAN'S COMPENSATION/COMPENSATION CLAIMS

I understand that this claim is being submitted as a compensation claim for an injury. If compensation is denied, I understand that I will be fully responsible for all charges.

PATIENT SIGNATURE ___________________________ DATE ___________________________

Patient Name:______________________________D.O.B____/____/_____

Please provide the name(s) of person(s) if any, to whom you would permit Reston Podiatry Associates, LTD (RPA) to disclose personal health information as necessary for your continued health care. Please also note if specific health care information cannot be disclosed (i.e.; test results, appointment information, etc.) Otherwise, we will disclose only what is necessary for your continued health care in accordance to this Privacy Policy.

List below those individuals (family, friends, interpreter services, etc.) you will allow disclosure of your personal health information from RPA as necessary during the course of your health care services:

Name and Relation (circle one)	Allowed Disclosures(s)	Please circle ALL or specify

Spouse: ____ All or
Specify:____

Family/Friend-Name_________________________________All or
Specify:____

Family/Friend-Name_________________________________All or
Specify:____

Family/Friend-Name_________________________________All or
Specify:____

_______________Initial if you will allow interpreter services if necessary for communication with health care providers

____**(Initial)** I acknowledge and understand that Reston Podiatry Associate's policy is to send copies of test results and/or other medical information to physicians who either ordered the procedure/consult or are in need of this health information to ensure coordinated and effective diagnosis and treatment. (i.e.; your designated primary care provider or physicians/ dentist seen for consult/treatment.) RPA's policy is to only disclose specific information necessary for coordination of your health care or medical treatment.

List below physicians who you **DO NOT** want specified private health information (PHI) sent, which could be sent in the usual course of facilitating or coordinating medical treatment.

DO NOT SEND PHI: Provider Name:_________________________All or Specify:___________________________

DO NOT SEND PHI: Provider Name:_________________________All or Specify:___________________________

___**(Initial)** I acknowledge and understand Reston Podiatry Associate's policy to contact me by various means when necessary for my health care services that may include my home/work/cell phone, fax, and/or email. I also understand that private health information may be included in that communication to me.

I **DO NOT** want RPA to use the following methods of communication which may include my private health information:
Please list:

______ **(Initial)** I hereby acknowledge that I have had the opportunity to read the Reston Podiatry Associates LTD Notice of Privacy Practices and received a copy (if requested).

Signature:_______________________________________ Date:______________________________

Printed Name:_____________________________________